Copic Application for Medical Professional Liability Insurance

Group Application

This is a claims-made policy. Please review your policy provisions carefully to understand and determine all of your rights and duties.

With your completed application, you are required to submit the following information:

- Current declarations page which provides a retroactive date and indicates limits of liability for which you are requesting coverage.
- Supplemental details as required
- A list of all organizations you would like listed as certificate holders for your coverage.
- A loss run report. To obtain this information, please call your prior carrier(s) and request a currently-valued loss run for the past ten (10) years

Additional information may be requested.

7351 E. Lowry Blvd., Ste. 400, Denver, CO 80230
P: 720.858.6000 ● F: 720.858.6004 ● TF: 800.421.1834 ● www.copic.com

APPLICANT DATA

1. Name of Primary Entity to be Insured: _____

   All other entities or DBA names to be insured: _____

   _____

   _____

2. Type of Practice

   ☐ Partnership ☐ Professional Corporation ☐ Provider Network ☐ LLC ☐ LLP ☐ Other: _____

3. Date Entity was Established: _____ 4. Tax ID/EPIN: _____

5. Primary Physical Practice Address: _____

   City: _____ County: _____ State: _____ ZIP: _____

   Primary Phone Number: _____ Secondary Phone Number: _____

   Primary Contact Email Address: _____ Primary Contact Phone Number: _____

   Rural Mailing Address/PO Box (if applicable): _____

   City: _____ State: _____ ZIP: _____

6. Billing Address (if different from practice location)

   Firm Name: _____

   Address: _____

   City: _____ County: _____ State: _____ ZIP: _____ Phone Number: _____

7. Preferred Mailing Address for Policy-Related Documents

   Choose one: ☐ Office ☐ PO Box ☐ Billing Address

CONTACTS

8. Practice Administrator/ Business Manager: _____ Title: _____

   Phone Number: _____ Email: _____

9. Policy Billing Contact: _____ Title: _____

   Phone Number: _____ Email: _____

10. Primary Risk Manager: _____ Title: _____

    Phone Number: _____ Email: _____

PROVIDER SUBMISSIONS

11. Please provide either applications or a complete roster for all employed/contracted physicians and allied health professionals who you will need covered under this policy.

    Note: The Copic policy provides no individual coverage to any employee or independent contractor in any of the classifications defined as a physician or allied health providers in the policy unless they are specifically named on the Declarations Page. The policy also provides no coverage to any physicians or allied health providers in a claim or suit for their acts or omissions unless their names specifically appear on the Declarations Page. If you employ anyone in any of the classifications defined as a physician or allied health provider in the policy forms and they are insured elsewhere, Copic may be willing to extend coverage to you for their acts or omissions subject to underwriting.

COVERAGE REQUESTED

12. Requested Effective Date: _____/_____/_____ Retroactive Date: _____/_____/_____

13. Limits of Liability Per Incident: $_____ Per Aggregate: $_____ (For example, $1M/$3M)

14. Would you like a quote including a deductible?..... ☐ Yes ☐ No

If "Yes," what amount? _____ Which Type: ☐ Indemnity Only ☐ Indemnity & Expenses

15. Would you like increased cyber liability or covered proceedings coverage?..... ☐ Yes ☐ No

If "Yes," a supplemental application will be required.

16. Premium Payment Plan:

You have the option of choosing the payment plan that best meets your needs. Please note that only one option may be selected.

☐ Quarterly (Four installments, three months apart)

☐ Semi-Annually (First half due at beginning, second half due in six months)

☐ Annually (Payment in full at beginning)

Mid-term policy changes may affect subsequent installment amounts.

PROFESSIONAL LIABILITY INSURANCE HISTORY

17. Policy Information

Name of Company: _____ Policy Limits: $_____ / $_____

Period of Coverage: (____/____) to (____/____) Retroactive Date: (____/____) to (____/____) ☐ Claims-Made ☐ Occurrence

Name of Company: _____ Policy Limits: $_____ / $_____

Period of Coverage: (____/____) to (____/____) Retroactive Date: (____/____) to (____/____) ☐ Claims-Made ☐ Occurrence

Name of Company: _____ Policy Limits: $_____ / $_____

Period of Coverage: (____/____) to (____/____) Retroactive Date: (____/____) to (____/____) ☐ Claims-Made ☐ Occurrence

18. Type of Coverage Desired:

☐ Claims-made coverage *with* prior acts coverage (If this option is chosen, move to Question 19.)

☐ Claims-made coverage *without* prior acts coverage (If this option is chosen, please complete the following:)

If claims-made coverage without prior acts coverage was selected and your most recent policy was issued on a claims-made basis, please indicate one of the following:

☐ An extended reporting endorsement (tail coverage) has been or will be purchased.

☐ An extended reporting endorsement (tail coverage) has not and will not be purchased. I understand that my failure to purchase such coverage from my current insurer could result in an uninsured claim which may arise as a result of professional services prior to joining Copic. I understand that the policy for which I am applying with Copic Insurance Company, if offered, will not provide coverage for incidents prior to my effective date of coverage.

Initial here to confirm your understanding: _____

19. Has an insurer ever cancelled, declined to issue, refused to renew, or issued coverage to any of the entities identified in question #1 or the employed/contracted providers of those entities?..... ☐ Yes ☐ No

PRACTICE CHARACTERISTICS

20. Please describe your medical practice operations: _____

_____

21. Is your organization qualified as a governmentally immune entity/organization? ..... ☐ Yes ☐ No

22. Are any of the entities identified in question #1 a freestanding and/or state-licensed facility or clinic? ..... ☐ Yes ☐ No

If "Yes," and more than one entity is listed in response to question #1, please list the entities here: _____

_____

Do any of the entities listed above require separate limits of liability? ..... ☐ Yes ☐ No

23. Are any of the entities identified in question #1 utilized by medical providers outside of your group affiliation?..... ☐ Yes ☐ No

If "Yes", and more than one entity is listed in question #1, please list the name of the entities here: _____

_____

24. Are any of the entities identified in question #1 a provider network? ..... ☐ Yes ☐ No

25. Including telemedicine, do any of your employed physicians or allied health providers provide medical or consultative services:

a. While located outside of your primary state of practice? ..... ☐ Yes ☐ No

b. To patients located outside of your primary state of practice? ..... ☐ Yes ☐ No

26. Do any of your providers act in the capacity of a medical director for another practice or facility?..... ☐ Yes ☐ No

27. Do any of your employed/contracted providers or administrative staff utilize any patient-facing artificial intelligence technologies, such as chatbots or similar tools in your practice? ..... ☐ Yes ☐ No

If "Yes," is the information being provided to the patient confirmed/reviewed? ..... ☐ Yes ☐ No

28. Do any of the providers employed or contracted with your practice perform any of the following procedures:

Autologous fat injections into penises ..... ☐ Yes ☐ No

Chelation therapy (other than for treatment of heavy metal poisoning) ..... ☐ Yes ☐ No

Elective home delivery..... ☐ Yes ☐ No

Sclerotherapy (the injection of sclerosing agents) into the vertebral column..... ☐ Yes ☐ No

Rapid opiate detoxification..... ☐ Yes ☐ No

Sperm banks for other than interim storage for insemination of your own patients..... ☐ Yes ☐ No

Water births ..... ☐ Yes ☐ No

Office-based surgeries or procedures which require sedation..... ☐ Yes ☐ No

29. Are any non-physicians supervised or employed by your practice involved in the management of active labor and any subsequent delivery for Vaginal Birth after Caesarean (VBAC) patients without a responsible physician physically on the premises and immediately available for the entire the course of care? ..... ☐ Yes ☐ No

30. Do any of your employed/contracted providers offer obstetric ultrasound images or videos created solely for nonmedical reasons or without an ultrasound report for the medical record or any nonmedical use of ultrasound imaging, such as "keepsake ultrasounds"? ..... ☐ Yes ☐ No

31. Do any of the providers employed or contracted with your practice perform aesthetic or cosmetic procedures? .....☐ Yes ☐ No

32. Do any of the providers employed or contracted with your practice provide gender-affirming care/services? ..... ☐ Yes ☐ No

If "Yes," do they offer/provide gender-affirming services, medical or surgical, to patients under 19 years of age? ..... ☐ Yes ☐ No

33. Do or will any of your entities' employees practice at a location geographically separate from either the primary or secondary practice address identified on page 1 of this application? ……..…… ☐ Yes ☐ No

If "Yes," please provide an explanation: _____

IF YOU PRACTICE IN A STATE WITH A PATIENT COMPENSATION FUND

34. If approved for Copic coverage, will you file evidence of this coverage as proof of financial responsibility to become qualified as a health care provider under a patient compensation fund? …….. ☐ Yes ☐ No ☐ N/A

35. Have you been a qualified health care provider under the fund at all times subsequent to the retroactive date requested above and as shown on the insurance declarations page(s) attached to the application? …… ☐ Yes ☐ No ☐ N/A*

(*"N/A" means that you do not practice within a fund state and, therefore, this question is not applicable.)

Note: Examples of states with patient compensation funds include Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, and Wisconsin. It is advisable to investigate specific regulations in each state where you practice to determine whether participation in the fund is voluntary.

CREDENTIALING AND RISK MANAGEMENT

36. Which of the following screening methods does your practice engage for all employed or contracted providers?

(Please mark all that apply)

☐ County-level criminal background screening ☐ Sex offenders registry screening ☐ Alcohol and drug screening

☐ State-level criminal background screening ☐ Verification of education ☐ Verification of training

☐ Federal criminal background screening ☐ Obtaining at least 2 peer references from previous employers or colleagues

37. Do you use any of the following abuse prevention methods?

a. Written sexual abuse and molestation prevention policy that is read and signed off by staff annually ……..…….. ☐ Yes ☐ No

b. Training on sexual abuse and molestation prevention provided to staff annually ……..…….. ☐ Yes ☐ No

c. An enforced zero tolerance policy regarding abuse ……..…….. ☐ Yes ☐ No

d. Written policy addressing abuse prevention ……..…….. ☐ Yes ☐ No

38. Are all employed or contracted providers credentialed prior to hiring? ……..…… ☐ Yes ☐ No

How often are providers re-credentialed? _____

39. Does the applicant use a third-party credentialing service? ……..……..…… ☐ Yes ☐ No

If "Yes," list the provider: _____

40. Have any of the entities identified in question #1 or the employed/contracted providers of those entities ever lost a license, been denied a license or been disciplined (probation, sanction, fines, etc.) by any governmental licensing agency, by any accrediting review body, or by any state or federal agency?……..…… ☐ Yes ☐ No

If "Yes," please explain: _____

41. Does your practice have a quality assurance and risk management program? ……..…….. ☐ Yes ☐ No

CLAIMS INFORMATION

Important information regarding questions 42 and 43 (including sub-questions):

1. The word "claim" as used in questions 42 and 43 below refers to:

a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or

b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.

2. If you answer "Yes" to question 42 and 43 (including sub-questions), please complete the attached Supplementary Claims Information Form.

42. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? …….…….…….. ☐ Yes ☐ No

43. Please indicate if you are aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:

a. A request for records from a patient and/or attorney related to an adverse outcome? ……..…….. ☐ Yes ☐ No

b. A letter from an attorney regarding your medical treatment of a patient? …….. ☐ Yes ☐ No

c. Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities? ……..…. ☐ Yes ☐ No

d. Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis? ……..…. ☐ Yes ☐ No

e. Any other circumstances that might reasonably lead to a claim or suit? ……..…. ☐ Yes ☐ No

44. If "Yes," to any of the above, have they been reported to your current or prior professional liability insurance carrier? …... ☐ Yes ☐ No

SUPPLEMENTARY CLAIMS INFORMATION FORM

If there has been more than one claim, please photocopy this form. Attach additional sheets, if needed.

All questions must be answered or marked Not Applicable (N/A).

1. Patient's Initials: _____

2. Date reported to insurance company: _____

3. Name of insurance company: _____

4. Date of incident and your treatment: _____

5. Allegations: _____
_____
_____

6. What is the present condition of the patient? _____
_____
_____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ..... ☐ Yes ☐ No

8. Status of claim (check applicable answer):

☐ Suit threatened, no action taken

☐ Suit filed but dropped by claimant

☐ Summary judgment in your favor

☐ Suit settled out of court
a. Date claim paid:_____
b. Amount paid: $_____
c. Did you want to settle this claim? ☐ Yes ☐ No

☐ Court outcome in your favor

☐ Court outcome in favor of plaintiff:
Amount of Loss payment:
$_____

☐ Awaiting mediation

☐ Awaiting court action:
Reserve Amount:
$_____

9. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? .....☐ Yes ☐ No
If "Yes," amount was $_____

Signature: _____ **Date**: _____

Name (Printed): _____

WARRANTY STATEMENT

The Applicant understands and agrees that all information contained in the application(s) and supplemental information submitted to Copic in connection with the insurance being applied for will be relied upon by Copic underwriters in issuing the policy and are the basis for the proposed insurance. Such application(s) and information submitted to Copic shall be deemed attached to, and made a part of, this Warranty Statement.

The Applicant also understands and agrees that the policy, for which this Warranty and application are made subject to its terms and conditions, does not apply to claims or potential claims the Applicant is aware of, or should be aware of after reasonable inquiry, prior to the effective date of coverage. All claims or potential claims should be reported to the Applicant's carrier prior to the effective date of the new policy.

The Applicant warrants, after reasonable inquiry, that it is not aware of any dispute, error, omission, act or circumstance that is, or could reasonably be expected to become, a claim under the policy of which the application(s) and supplemental information are submitted to Copic, including, but not limited to, an attorney's request for records, patient/family dissatisfaction, or unanticipated death/paralysis/disability.

☐ Check this box if the Applicant warrants that the above statements are true.

I. By signing below, the Applicant warrants that the foregoing is true and complete and acknowledges that the insurer is relying on the accuracy of this statement in acceptance of the risk. This does not bind the company to offer insurance.

II. The Applicant acknowledges and agrees that this warranty statement shall be the basis of the proposed insurance and shall be considered incorporated into and constituting part of the proposed insurance.

III. The Applicant agrees that if the information supplied on this warranty statement changes between the date of the warranty statement and the inception date of the insurance, the Applicant will immediately notify the insurer of such a change, and the insurer may modify or deny coverage.

Print Name: _____ Title: _____

Signed: _____ Date _____

Authorized signature of a Principal or Officer

(Must be signed and dated no more than 45 days prior to binding)

UNDERSTANDING, AUTHORIZATION, AND RELEASE OF INFORMATION

The applicant hereby declares and represents that all answers and statements in this application are true and complete to the best of their knowledge and that no material fact or circumstance concerning the subject matter of this application has been omitted or withheld. The applicant understands that these answers and statements are material and, as such, will be relied upon by Copic to determine whether to issue the applicant's liability insurance, to determine the amount of limits available, or to specifically exclude a risk. If the applicant or any other person making application or providing information on the applicant's behalf misstate(s) or fail(s) to disclose any material information, the application may be declined. If the application is approved and it includes any material misstatement or it fails to disclose material information, Copic has the right to rescind the insurance. Copic also has the right to decline coverage for a specific claim if Copic would have declined to issue insurance or would have limited the coverage if the applicant had not made the material misstatement or omission.

By submitting this application, authorization is given to any state board of medical examiners or medical board, or any licensure, hospital board or committee, hospital records department, insurance company, professional society, past or present association, business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to Copic or its assigns. This authorization applies regardless of whether the applicant is currently affiliated with the above persons or entities, or has been in the past. The applicant authorizes the use of a copy of this authorization in lieu of its original.

As may be permitted by law and in compliance with Copic policy, consent is provided to Copic's release of the following information about insureds under this policy, which may change from time to time, to credentials verification organizations, health plans, hospitals, health care organizations (including professional societies or associations), professional liability insurance carriers, and state and federal regulatory entities, including but not limited to medical boards and boards of medical examiners, the National Practitioners Data Bank and the Healthcare Integrity and Protection Data Bank. This release applies to the following information: insured(s) name, business address, NPI number, license number, hospital affiliations, policy numbers, effective dates, limits of liability, retroactive date, specialty, PLI rate class, and any information concerning those claims which are required to be reported to any state board of medical examiners or medical licensing body or authority, National Practitioners Data Bank and/or the Healthcare Integrity and Protection Data Bank. To the fullest extent permitted by law, the applicant herby releases all providers of such information, including Copic, its employees and agents, from any and all liability therefore.

Authorized Representative signature _____ Date _____

Please PRINT your name _____

RETAIN A COMPLETED COPY OF THIS APPLICATION FOR YOUR RECORDS

Please check this application to ensure that you have answered all questions and included all requested attachments. Submitting an incomplete application could result in a delay in underwriting and processing or an outright rejection of your application.

INSURANCE FRAUD WARNINGS

The following Insurance Fraud Warnings are required to be provided with all applications.

CALIFORNIA

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

ALABAMA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ARKANSAS

Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include Imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from Insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false Information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LOUISIANA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may subject to civil fines and criminal penalties.

NEW YORK

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON

Any person who knowingly provides false, incomplete, or misleading material information to an insurance company with the intent to knowingly defraud may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

RHODE ISLAND

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

VIRGINIA

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WASHINGTON

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WEST VIRGINIA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

With respect to all other states, please be advised of the following:

GENERAL FRAUD WARNING

Insurance fraud is committed when a person knowingly and with intent to defraud or deceive supplies false, incomplete or misleading information concerning any fact or thing material to an insurance policy. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who knowingly attempts to commit insurance fraud is subject to civil action by the Company and shall be reported to the appropriate law enforcement authority.